

George W. Meyer, MD FACP MACG, Series Editor

Unusual Causes of Abdominal Pain

CASE

A 43 year old male with no past medical history presented to ER complaining of right lower quadrant pain for 3 days. He described the pain as sharp, constant, 8/10 in intensity, non-radiating, localized to the right lower quadrant, associated with nausea and worsened with coughing. He denied associated fevers, vomiting, diarrhea or constipation.

Vital signs on presentation showed temperature 98.1°F, blood pressure 130/84 mmHg, heart rate 80 beats/min, and respiratory rate of 20 breaths/min. On physical examination his abdomen was tense, non-distended, and normal bowel sounds were present. Patient was tender in RLQ with positive guarding, but no rebound. He was Dunphy's sign positive. No tenderness at McBurney's point noted. Rovsing's sign, Obturator sign and Psoas sign were negative. No visible or palpable hernias were noted with and without coughing. The remainder of physical examination was unremarkable. Laboratory analysis showed a white blood cell (WBC) count of 9.5 K/UI with 39% neutrophil count. The remainder of the laboratory tests were within normal limits. CT scan of Abdomen/Pelvis with contrast confirmed the diagnosis. Patient improved with conservative treatment and NSAIDS.

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UNUSUAL CAUSES OF ABDOMINAL PAIN

We solicit our readers to submit interesting and unusual cases of abdominal pain for consideration for publication.

The case should be well documented, include images (if possible), at least one reference and no more than two authors.

Send your manuscript to
Dr. George Meyer at:
geowmeyer@gmail.com

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Figure 1. |CT Abd/Pel: fatty infiltration anterior to the cecum consistent with right lower quadrant epiploic appendagitis.

ANSWER AND DISCUSSION

Around 5% of all ER visits are due to a complaint of acute abdominal pain. Epiploic appendagitis (EA) also known as appendixes epiploica, hemorrhagic epiploitis, epiplopericolitis and appendicitis epiploica, is a fairly rare, benign condition of the epiploic appendages that occurs due to torsion or spontaneous venous thrombosis of a draining vein of the epiploic appendage. The resulting strangulation and inflammation leads to localized abdominal pain.

EA most commonly occurring in the second to fifth decades of life, with slightly higher incidence in middle aged males, although, it can affect anyone including young and healthy individuals. Obesity and heavy exercise are thought to be potential risk factors. First described by Vesalius in 1543, about 100 pedunculated fatty structures, also known as epiploic appendages, protrude from the serosal surface of the colon from the cecum to the recto-sigmoid junction. The average length of epiploic appendage is 3 cm, but can be as long as 15cm in length. Clustering in the sigmoid and cecal regions is what leads to the mistaken diagnosis

of diverticulitis and appendicitis when the epiploic appendages become torsed or inflamed. Patients most commonly present with acute abdominal pain, more often in the left lower than right lower quadrant, without associated leukocytosis or fever. One-third of patients will have an elevated C-reactive protein.

EA is recognized and diagnosed with the use of ultrasound or CT scan, with CT scan being more sensitive and specific. EA should be entertained when diverticulitis, appendicitis and other causes of acute abdomen are ruled out. On CT scan EA presents as an oval shaped fat density, paracolic mass with fat stranding and thickened peritoneal lining. In addition, a central hyper-attenuating dot representing an engorged or thrombosed draining vein may be seen on CT. Complete resolution of symptoms typically occurs within 2 weeks with conservative treatment, primarily anti-inflammatory agents. No hospitalization or antibiotic use is required. Improved awareness of EA presentation as an acute abdomen will prevent unnecessary medical procedures and surgical interventions. ■

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